Department of Health and Family Services
Division of Health Care Financing
HCF 13174 (Formerly HCF 1113) (Rev. 10/05)

State of Wisconsin

ESTATE RECOVERY PROGRAM
HEIR INFORMATION

****To be used whenever money is sent to anyone or anywhere other than to the Estate Recovery Program****
Personal identifiable information will be used only in the administration of the Estate Recover Program

Name of Deceased Resident	Social Security Number	Date of Death

Total Amount of Funds at Nursing Home (including patient account and excess patient liability) ☐ Patient Account ☐ Excess Patient Liability	Dates Resident Resided in Nursing Home From To

Does the deceased have a surviving spouse?	☐ Yes	☐ No	☐ Unknown
Does the deceased have any surviving minor children under the age of 21?	☐ Yes	☐ No	☐ Unknown
Does the deceased have any surviving disabled children?	☐ Yes	☐ No	☐ Unknown

INFORMATION ABOUT THE PERSON OR PLACE TO WHOM THE FUNDS WERE CONVEYED

Name of Heir, Guardian or Place	Address	City, State and Zip Code

Relationship to deceased resident	Telephone Number

INFORMATION ABOUT THE PERSON WHO CONVEYED THE FUNDS

Name of Person Who Conveyed Funds	Title	Amount Conveyed

Name of Nursing Home/Facility	Address	City, State, and Zip Code

Telephone Number

Please mail this completed form to:

Division of Health Care Financing.
Estate Recovery Program
P.O. Box 309
Madison, WI 53701-0309